

MATTERS ARISING

Syndromic management of genital ulcer disease

Professor Kumar and his colleagues question the use of the syndromic approach for the treatment of patients presenting with genital ulcer disease (GUD), (*Genitourin Med* 1995;71:197). Their main criticisms against its use are based on clinical grounds, namely that the wrong diagnosis might be made and that this could result in distress to the patient. Both of these concerns are legitimate observations from a clinician's point of view but must be weighed against public health imperatives. Most countries in the world have to develop control programmes for sexually transmitted diseases (STDs) under the constraints that the majority of patients with a possible STD will be seen in a rural setting, by non-medical personnel with no laboratory support and limited financial resources.

The World Health Organisation (WHO) has correctly taken a public health strategy to control rather than recommending a specialist-based approach with full laboratory support. The reality of STD management in developing countries is that such care is provided through an array of services and individuals. This will obviously include specialist STD clinics but also general hospital outpatients, primary health care centres, maternal and child health facilities, family planning, private practice as well as pharmacists, traditional healers, quacks, street vendors etc. These realities require a pragmatic response. A specialist laboratory-based programme does not do this and is bad public health medicine. More people will be reached by the use of the syndromic approach delivered through an integrated system, often at primary health care level or through maternal and child health programmes. Naturally, this will be complemented by specialist STD clinics.

The three tasks, and challenges to all of us, in controlling STDs is to: (1) Develop effective health education and encourage appropriate health seeking behaviour, (2) Train staff, usually non-medical, to recognise the basic symptoms and signs and deliver appropriate therapy, (3) Use and modify the syndromic approach to local needs and antimicrobial sensitivities.

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Syndromic management of genital ulcer disease—a response

Kumar *et al* have offered a critical appraisal of the syndromic approach to management of genital ulcer currently advocated by the WHO and call for views and suggestions from other physicians from developing countries.¹ I write as a physician with six and a half years experience of working with STD patients in a developing country (Papua New Guinea) where I developed a keen

interest in efforts to find ways to improve services to STD patients.

In their letter Kumar *et al* clearly favour the evaluation of STD patients by properly trained specialists with full laboratory support. They describe many potential problems that might arise from the widespread adoption of a syndromic approach to STD case management which even the most partisan advocates of this approach would have to accept as quite legitimate, although one might make exceptions for their point about partner management, the need for which is explicitly stated in all versions of the WHO flow charts that I have seen. I would be most surprised if the number of genital ulcers seen in their clinic which can be attributed to non-STD causes such as the feminine hygiene sprays(!), on which they place such strong emphasis, amount to more than 5% of the total.

What Kumar *et al* do not do is to offer any alternative ideas about how services can be improved for the huge numbers of STD patients who seek treatment for STDs outside the specialist sector for reasons of difficulty of access, cost, fear of stigmatisation etc. Such patients in developing countries greatly outnumber the few who attend specialist STD clinics and in most cases they attend centres without access to any more than the most basic laboratory facilities.

The syndromic approach to STD case management was developed with the aim of helping such patients to receive more appropriate treatment. It was not designed primarily for specialist clinics although well-equipped specialist clinics can play a valuable role in designing, adapting and evaluating locally appropriate flowcharts. It is generally accepted that the syndromic approach has many imperfections and requires careful evaluation for efficacy, cost, adverse drug reactions, and impact on antimicrobial susceptibilities in comparison with more traditional models of care. The results of such studies are keenly awaited.

There appears to be an unfortunate polarisation amongst physicians involved in the care of STD patients between those who advocate and those who oppose syndromic case management. This debate has echoes in broader and frequently acrimonious debates about the role of clinical guidelines in contemporary medicine. On the one hand stand a conservative lobby of traditional specialist venereologists who vigorously defend their clinical autonomy and strive to maintain high standards for a small number of patients. They tend to view the innovative public health approach to STD control advocated by the WHO as an encroachment on their specialist territory and an imposition by non-specialist epidemiologists. On the other hand stands a more radical, public-health oriented group who point out the inability of traditional specialist clinic based services to make any real impact on the huge burden of STDs in developing countries and, in particular on the rapid spread of HIV, and who argue that the routine management of common STDs must be made an essential skill for primary health care workers in settings where the prevalence of STDs is high. I would like to make a plea for those on both sides of the divide to acknowledge that we still do not know which of the currently available approaches to STD case management has the most favourable impact on control and that all those involved in the care of STD patients have a responsibility to try and develop new models of care and to

carry out well-designed studies to compare the efficacy of newer and older approaches to STD case management which can be used to guide future policy.

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1 Kumar B, Handa S, Dawn G. Syndromic management of genital ulcer disease—a critical appraisal. *Genitourin Med* 1995;71:197.

Chlamydia in women: the more you look, the more you find

Hay *et al*, in a paper entitled *Chlamydia trachomatis: the more you look, the more you find*,¹ and using a direct fluorescent antibody test, found that swabbing the cervix alone to detect genital *Chlamydia trachomatis* carriage in women, probably missed 10% of cases. These women were apparently carrying chlamydia in the urethra.

We have tried to reproduce these results using the Syva Chlamydia enzyme immunoassay (EIA) to screen samples, and direct immunofluorescence of the centrifuged deposit to confirm (Syva DFA).

Two hundred women presenting with a new episode were screened by taking both a cervical and a urethral swab for chlamydia. The prevalence was 5.5% (11 of 200), which was lower than Hay *et al*'s 29%, but more compatible with the 5–10% figure which they quote as normal for clinic attenders. Of the 11 confirmed chlamydia positive samples, 7 were from the cervix only, 2 were from the urethra only, and 2 were from both the cervix and urethra. Thus, 2 of 11 cases of chlamydia would have been missed.

In addition to this study, we carried out a survey of clinics to assess standard practice since the publication of Hay *et al*'s paper, and the results suggest little change from traditional cervical swabbing alone.

Larger genitourinary medicine centres in the UK were circulated with a questionnaire containing two questions:-

1. Which chlamydia swabs do you routinely carry out in female patients in your clinic? Cervical ☐ Urethral ☐
2. Has your practice changed in the last year? Yes ☐ No ☐

We received 12 replies and the results were as follows:-

Cervical swab only	9
Cervical and urethral swabs	3
Changed practice	1
Unchanged practice	11

(The one clinic whose practice had changed, indicated that the cervix was only swabbed currently).

Thus, apparently no clinics had changed their practice to two-site swabbing, despite the findings of Hay *et al*'s paper, and although double-swabbing has resource implications, the increased yield would appear to justify it.

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1 Hay PE, Thomas BJ, Horner PJ, Macleod E, Renton AM, Taylor-Robinson D. *Chlamydia trachomatis* in women: the more you look, the more you find. *Genitourin Med* 1994;70: 97–100.